evaluated cognitive behaviour therapy: there were insufficient studies on the possible effects of motivational interviewing or psychoanalytical therapies.[3]

What other gaps in the evidence need filling? Carefully designed interventions aimed at facilitating family cohesion may prove beneficial, given previous evidence.[11] In all childhood illnesses, but none more so than diabetes, successful management necessitates continuous collaboration and sharing of responsibilities between parents or other carers and the child or adolescent. With increasing maturity, more responsibility passes to the teenager, and issues around family responsibility sometimes cause intense conflict. In addition, peer group pressure and behaviour can exert an important influence on adherence to treatment.[w5] Metabolic control often deteriorates in adolescence, and consistent preventative management and strategies for early intervention become even more important.[w4]

Finally, cultural differences influence many aspects of diabetes care. Factors such as health beliefs, cultural lifestyles, religion, eating habits, peer group behaviour patterns, family traditions, and healthcare structure are all important.[12] As well as sensitive communication and reciprocal support between young people and their families and professional health carers, understanding of family beliefs often plays a pivotal role in the outcomes of treatment.

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Better services and more choice in the NHS

Leaders should not ignore the pitfalls and benefits of bringing services to the doorstep

The English public wants three things from community services: to have more control of their health and care; support and enablement to maintain their health, independence, and wellbeing; and rapid and convenient access to high quality, cost effective care, closer to their homes.[1 2] Hence, in a white paper—*Our Health, Our Care, Our Say: A New Direction for Community Services*—earlier this year the Department of Health recommended a substantial transfer of NHS functions to the community, proposing that up to 15 million outpatient attendances should be delivered in community settings.[1]

To avoid fragmentation, control of most local health resources will be given to general practices via practice based commissioning while primary care trusts develop the necessary infrastructures to shift specialist care. Primary care trusts will be given the incentives for change through the mechanism of payment by results, a method already being used with hospital trusts to pay providers a fixed price for each individual case treated.[3] These plans require considerable investment in infrastructure and training, and considerable changes in working practices for many healthcare professionals.

The 2006 white paper suggested a range of clinical activities and procedures that could be performed outside the acute hospital by consultants, trainees, general practitioners, or allied health professionals, citing the example of polyclinics in Germany (Medizinische Versorgungszentren—MVZ, medical care centres).[1] Specialist outreach clinics gained currency after the NHS reforms of 1992, and although the Department of Health has now ruled them out,[1] the evidence of their popularity with patients is overwhelming. The largest evaluation of specialist outreach in the United Kingdom showed that outreach clinics, compared with outpatients' clinics, increased patient satisfaction, and improved access to specialist care and processes of care in all relevant specialties. Patients reported significant but small benefits to health at six month follow-up.[4]

Furthermore, referral rates to hospital outpatient clinics from general practices with outreach declined over time, and specialists working in outreach settings made fewer follow-up appointments than did those in

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conventional outpatient departments. Outreach clinics were, however, associated with higher NHS costs per patient owing to factors which included lower patient volume, lack of access to diagnostic facilities, and loss of efficiency arising from specialists having to travel between clinics.

A multicentre randomised controlled trial of the effectiveness and costs of video conferencing showed there was no need for consultants to travel to deliver outreach services. Patient satisfaction was improved and ordering of investigations was reduced, although the investigations were mainly the cheaper, routine tests and not the more complex expensive ones.[5] As with conventional outreach, such virtual outreach was considerably cheaper for patients to access than conventional outpatient services, but was considerably more expensive, per patient, to the NHS.[6]

Current plans for bringing specialties out of hospitals and nearer to people also include the development of new community hospitals to provide diagnostic services, minor elective surgery, outpatient facilities, social services, and a new NHS "life check" to assess patients' lifestyle risks.[2] Duplication of investigative facilities will be inevitable with such "one stop shops," as will substantial capital costs for buildings and equipment and considerable additional human resource costs. Furthermore, the NHS costs of having general practitioners with special interests covering several local practices can exceed those of hospital outpatient care.[7]

Little is known about the extent of necessary capital investment, nor indeed the impact on hospitals of retrenchment and wasted capital assets. And patients in inner cities, within walking distance of accident and emergency departments, will probably not welcome being obliged to use a general practice amenity that has fewer properly staffed investigative facilities, even if the practice is closer to home.

Evidence of the effectiveness and economic advantage of providing acute primary health care in hospitals is long standing and robust.[8] Faced with growing financial pressures, hospitals will need to innovate and reconfigure in order to survive. Redeployment of the current vast and complex secondary care asset structure could enable the delivery of a broad range of services that local communities seek and also the potential to franchise space to enable others to do the same. Until now, experience of this kind in the UK has been restricted largely to specific specialties or conditions. However, in countries with relatively fewer primary care physicians (such as the US), such models of hospital based delivery of general community services have been implemented successfully, particularly in areas with deprived populations (for example, Yale-New Haven Hospital Community Service, www.ynhh.org/commsvs.html). Comparative evaluation of the costs and effectiveness of hospital and community based models of service provision will be required in order to assess their relative merits.

The greatest challenge to health policy in England is how best to establish and balance optimum clinic size and range of services while ensuring high quality, efficiency, and cost effectiveness. In making those judgments, leaders of the NHS reforms will do well to draw on lessons learnt from past experience.

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Tuberculosis and social exclusion

Developed countries need new strategies for controlling tuberculosis

In developed countries most patients with tuberculosis are not infectious, can readily access health services, and complete treatment successfully with minimal supervision from a health worker. As a result they make only limited demands on services and pose little public health risk. By contrast, many socially excluded patients are at risk of delayed presentation, poor adherence, and loss to follow-up. A recent persistent outbreak in London including over 220 drug resistant cases and disproportionately affecting homeless people, prisoners, and problem drug users clearly illustrates the urgent need to strengthen tuberculosis control among socially excluded groups.[1]

Mycobacterium tuberculosis can infect anyone but predominantly affects the poor. Globally, 98% of deaths from tuberculosis are in the poorest countries.[2]

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